REPORT OF HEALTH CARE SERVICE PLANS' PROVIDER DISPUTE RESOLUTION MECHANISMS

2005 ANNUAL REPORT

February 24, 2006

THE 2005 REPORT ON PROVIDER DISPUTE RESOLUTION MECHANISMS OF CALIFORNIA HEALTH CARE SERVICE PLANS

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I.

Executive Summary

This 2005 Dispute Resolution Mechanisms Report is the second annual report submitted by the Department of Managed Health Care (Department), pursuant to Health and Safety Code section 1367(e). This report summarizes provider dispute information from October 1, 2004, through September 30, 2005. The following summarizes the data reported by type of health plan for the 2005 reporting period:

Full-Service Health Plans

- The 40 active California full-service health plans processed approximately 146 million claims in the 2005 reporting period.
- They received 427,898 provider disputes.
- They experienced a 71 percent increase in the number of provider disputes received, as compared to the 2004 reporting period.
- One provider dispute was filed for every 343 claims processed.
- The seven largest health plans (Kaiser, Blue Cross, Blue Shield, Health Net, PacifiCare, Aetna, and Cigna) processed 93 percent of the claims, and received 87 percent of the provider disputes.
- 387,508 provider disputes involved claims payment and/or billing problems.
- Providers prevailed in 53 percent of all provider disputes, suggesting that dispute resolution mechanisms do provide a way to resolve provider disputes without resorting to costly civil litigation.

Specialized Health Plans

- California's 52 specialized plans received 7,678 provider disputes during the 2005 reporting period.
- They experienced a 74 percent increase in the number of provider disputes received, as compared to the 2004 reporting.
- As anticipated, behavioral health plans, which provide a broad spectrum of benefits as compared to other specialized plans, reported 71 percent of the provider disputes.
- 6,175 provider disputes involved claims payment and/or billing problems.
- 56 percent of all provider disputes were resolved in favor of the provider.

Capitated Providers

- Plans reported data on 432 capitated providers.
- Capitated providers received 151,390 provider disputes.
- 148,799 provider disputes involved claims payment and/or billing problems.
- 46 percent of all provider disputes were resolved in favor of the provider.

- The capitated provider data is new, and only includes information for part of the reporting period.

New to the report this year is information obtained through the Department's new Provider Complaint Unit, as well as the results of its audits of health care service plans.

Provider Complaint Unit

On September 20, 2004, the Department) introduced its Provider Complaint Unit, which developed an automated web-portal to allow health care providers to electronically submit claim reimbursement disputes. During the period October 1, 2004, to September 30, 2005, the Department received 1,103 complaints and recovered additional funds of $332,581 for health care providers

Audits of Health Care Service Plans

In February 2005, the Department began auditing payor dispute resolution processes to verify the accuracy and adequacy of the self-reported information, completing 19 audits by September 2005.

II.

Introduction

Assembly Bill 1455 (Stats. 2000, ch. 827) and Senate Bill 1177 (Stats. 2000, ch. 825) address complaints from health care providers that health care service plans (plans) were not paying claims in a timely manner. In addition to establishing new claims payment standards, these bills mandate that plans institute and maintain a fast, fair, and cost-effective dispute resolution mechanism for resolving contracted and non-contracted provider claims payment disputes. Health and Safety Code section 1367(h)(3) provides that:

> On and after January 1, 2002, each health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilize the dispute resolution mechanism and a summary of the disposition of those disputes.

Section 1375.7(e) of the Health and Safety Code (AB 2907, stats. 2002, ch. 925) directs the Department to compile information submitted by plans pursuant to subdivision (h) of section 1367 into a report to the Governor and the Legislature by March 15th of each calendar year.

In 2003, the Department promulgated regulations establishing specific standards and safeguards for the timely and accurate payment of claims, and for the establishment of a fast, fair, and cost-effective dispute resolution mechanism. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans and their capitated providers[1] who pay claims (capitated providers) to fully implement the standards and safeguards specified in the regulations by January 1, 2004.[2] The regulations define key concepts such as complete claim, information necessary to determine payor liability, reimbursement of a claim, date of receipt, date of payment, and provider dispute. The regulations apply to provider claims for services rendered on or after January 1, 2004.

The regulations apply to all payors[3] and set forth the requirements for a fast, fair, and cost-effective dispute resolution process, and require payors to resolve provider disputes. In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require plans to submit an Annual Plan Dispute Resolution Mechanism Report, which is public information, and

[1] Generally, capitated providers fall within two main categories: (1) medical groups and independent practice associations (also known as risk-bearing organizations), and (2) hospital systems that receive capitation from health plans, and in turn reimburse provider claims for health care services rendered to the plan's enrollees. Capitation is a set amount of prepaid money received or paid out, based on the number of enrollees assigned to an organization, rather than on the level of services delivered. This arrangement is usually expressed in units of PMPM (per member per month).

[2] California Code of Regulations, title 28, sections 1300.71 and 1300.71.38 became effective on August 23, 2003.

[3] Collectively, health plans and their capitated providers are referred to as payors.

contains: (1) information on the number and types of providers utilizing the dispute resolution mechanism; (2) a summary of the disposition of all provider disputes, including an informative description of the types, terms, and resolution; (3) the timeliness of dispute resolution determinations; and (4) a detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care. Health plans are also required to report on the dispute resolution results of their capitated providers.

This report reflects information compiled during the reporting period of October 1, 2004, through September 30, 2005. The following table shows the number of payors submitting provider dispute information during the reporting period:

	Total Entities Reported	Number of Disputes Received
Full Service Health Plans	42*	427,898
Specialized Health Plans	52	7,678
Capitated Providers	418	151,390
Total (All)	**512**	**586,966**

* Only 40 full service health plans are included in this report. Two health plans are exempted because they carry only Medicare products.

Payors summarized their provider dispute results in three categories:

- Claims Payment/Billing Disputes -- provider complaints relating to the payors' failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.

- Utilization Management Disputes -- provider complaints relating to medical necessity and authorization determinations.

- Other Disputes -- provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

The Provider Complaint Unit developed an automated web-portal to allow health care providers to electronically submit claim reimbursement disputes to the Department. This unit identifies and

tracks trends through its review of individual provider complaints. This enables the Department to focus on patterns of unfair payment and to ensure that payors remain compliant with the claims timeliness and accuracy requirements.

The Department, in collaboration with industry stakeholders, continues to refine the requirements for appropriately monitoring dispute resolution activity. As of February 2005, the Department began auditing the health plans' dispute resolution processes to verify the accuracy and adequacy of the self-reported information contained in this report. These refinements, along with the auditing process, should allow the Department to determine the relative density of disputes between institutional (hospital) and professional (physicians and other licensed health care professionals) providers, and correlate that with the number of licensed hospitals and physicians in California. As a result, additional detailed information regarding payor dispute resolution processes should be available for future reports.

III.

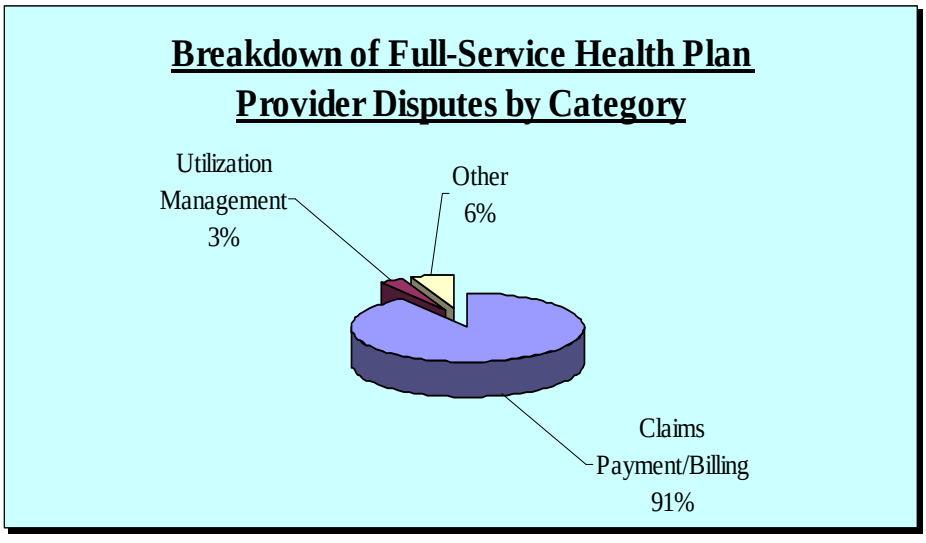
Reporting by Full-Service Health Plans

Data from 40 active full-service health plans is included in this report. Two full-service health plans, Scan Health Plan and Inter Valley Health Plan, are excluded from this report because they maintained only Medicare products, and are therefore exempt from the application of Health and Safety Code section 1367(h) on the basis of federal preemption.

These 40 full-service health plans received 427,898 provider disputes during the 2005 reporting period, and processed approximately 146 million health care claims. The number of provider disputes received by full-service health plans in the 2005 reporting period increased by 71 percent compared to the 2004 reporting period (October 1, 2003, to September 30, 2004). The Department has not been able to correlate the increase in provider complaints to an increase in claims payment deficiencies. It is more likely that a significant portion of this increase can be attributed to improved accuracy in collection and reporting procedures by health plans, and a greater awareness of this process by health care providers.

Claims payment/billing disputes primarily involving claims of inadequate reimbursement comprised 91 percent of the full-service health plan provider disputes. The 2005 reporting reflects the following breakdown of provider disputes:

Total number of claims payment/billing disputes	387,508
Total number of utilization management disputes	14,695
Total number of other disputes	25,695



Approximately 87 percent of all provider disputes filed with full-service health plans were reported as being resolved within 45 working days from the date of receipt -- within the timeframes set forth in the Department's claims payment and dispute resolution mechanism regulations. Plans continue to make vast improvements in the timeliness of resolving provider disputes as compared to previous reporting years. Health plans reporting untimely resolution of provider disputes described the corrective action measures instituted to ensure future compliance with the timeliness standard. Examples of self-reported corrective actions included updating computer systems, instituting daily internal management reports, educating providers with on-line training and/or newsletters, and increasing staff levels.

The Department will be monitoring the corrective action initiatives of the deficient health plans through financial examinations and by reviewing the provider complaints received by the Provider Complaint Unit. By employing additional outreach, monitoring, and reporting requirements, the Department anticipates significant improvement in timely resolution of provider disputes in the 2006-reporting year.

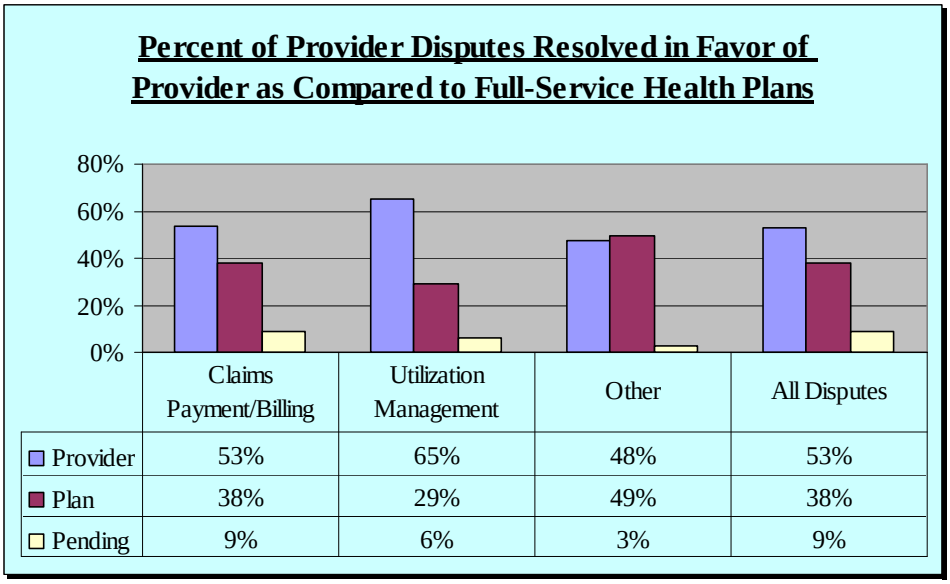
Analysis Comparing Provider Disputes to Claims Processed and Enrollment

Effective January 1, 2004, health care plans were required to report the total number of claims processed during the reporting period. A claim is processed when the health plan has paid, denied, adjusted, or contested it.

Health plan summaries reported that of the 146 million claims processed during the reporting period, only 387,508 claims challenged the appropriateness of reimbursement determinations. While each provider dispute is important, from a system standpoint, this is a small number. Statistically, this means that less than three-tenths of one percent (0.26%) of all claims processed by full-service health plans were claim payment/billing disputes. Payors were only receiving one provider dispute claim for every 379 claims processed, and only one provider dispute was filed for every 51 enrollees.

Summary of the Disposition of Full-Service Health Plan Provider Disputes

Full-service heath plans reported in 2005 that 53 percent of disputes between providers and health plans were resolved in favor of the provider, a decrease of four percent over 2004. Of the 427,898 provider disputes submitted, 228,410 were determined in favor of the provider, 163,256 in favor of the plan, and 36,232 were pending review as of September 30, 2005. The following graph illustrates the breakdown by percentages for each dispute category.



	Claims Payment/Billing	Utilization Management	Other	All Disputes
Provider	53%	65%	48%	53%
Plan	38%	29%	49%	38%
Pending	9%	6%	3%	9%

The high percentage of favorable rulings for providers suggests that health plan dispute resolution mechanisms resolve provider disputes without resorting to costly civil litigation. To determine, however, whether the relatively high overturn rate is related to uncorrected systemic claims-payment deficiencies, the Department plans to study each plan's dispute resolution mechanism as part of the claims audit process, and will require corrective action if necessary.

Comparison of the Seven Largest Full-Service Health Plans

California's seven largest full-service health plans provide health care benefits to over 18.1 million (83 percent) of the approximately 22 million enrollees. Eighty-seven percent of the disputes are filed with these seven plans, and they processed more than 136 million claims in 2005 – accounting for 93 percent of all claims filed by full-service health plans in California.

The following summary shows each of the seven plan's reported dispute resolution activities during the 2005 reporting period.

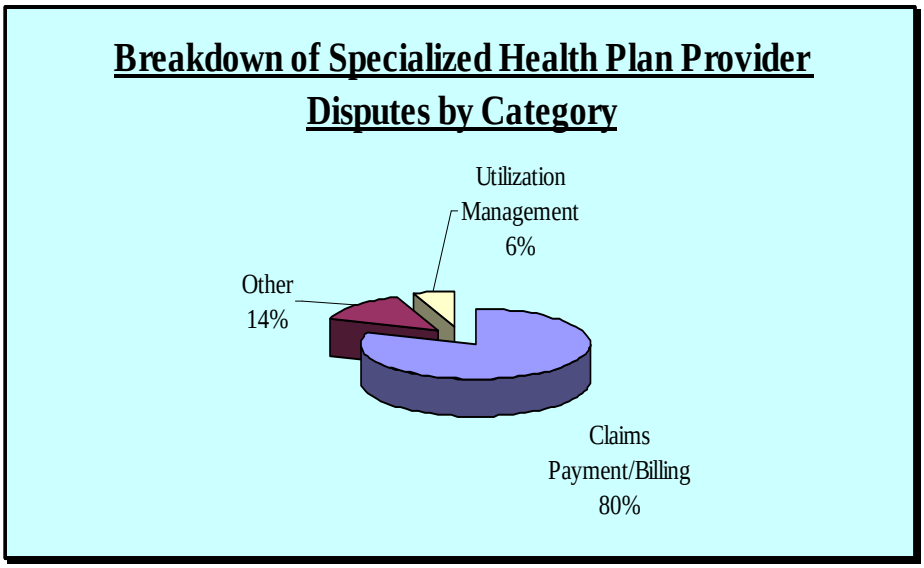
Name of Health Plan	Total Enrollment	Approximate Number of Claims Processed	Number of Disputes Received	Total Disputes in Favor of the Provider	Total Disputes in Favor of the Health Plan	Total Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Aetna Health of California	288,388	1,765,652	9,055	4,720	4,301	34	99%
Blue Cross of California	4,558,482	84,820,506	88,283	37,304	37,063	13,916	80%
California Physicians' Service (Blue Shield of California)	2,715,696	23,621,535	75,527	37,418	33,416	4,693	90%
Cigna HealthCare of California, Inc.	344,777	894,292	17,072	13,015	4,057	0	92%
Health Net of California, Inc.	2,052,323	21,859,757	97,714	67,470	17,484	12,760	78%
Kaiser Foundation Health Plan, Inc.	6,552,801	1,864,654	60,087	22,648	37,424	15	98%
PacifiCare of California	1,658,452	1,184,178	22,693	11,260	11,433	0	100%
Total Seven Largest Health Plans	**18,170,919**	**136,010,574**	**370,431**	**193,835**	**145,178**	**31,418**	**-**
All Other Full Service Health Plans	3,960,051	10,957,198	57,467	34,575	18,078	4,814	80%
Total (All Full Service Health Plans)	**22,130,970**	**146,967,772**	**427,898**	**228,410**	**163,256**	**36,232**	**-**

IV.

Reporting by Specialized Health Plans

California's 52 specialized plans reported receiving 7,678 provider disputes during the 2005 reporting period, a 74 percent increase from the 4,416 received during 2004. Similar to full-service health plan reporting results, the majority of provider disputes (80 percent) submitted to specialized health plans are claims payment/billing disputes. The 2005 reporting period reflects the following breakdown of provider disputes:

Total number of claims payment/billing disputes	6,175
Total number of utilization management disputes	447
Total number of other disputes	1,056



Approximately 86 percent of all provider disputes filed with specialized health plans were reported as being resolved within 45 working days from the date of receipt. To reduce the number of disputes received, some of the specialized health plans continue to address problematic areas that may result in recurrent disputes with the providers. In addition, the specialized health plans are working with providers to secure mutual agreement on disputed contractual terms.

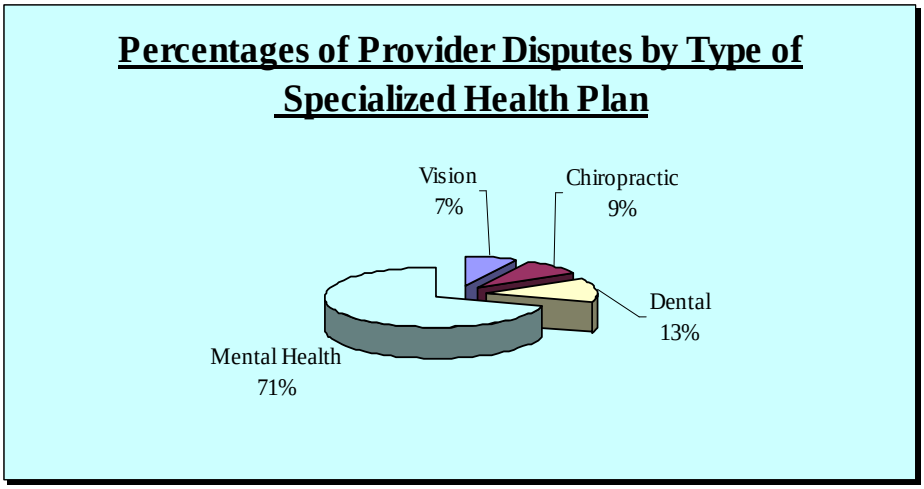
Reported Disputes by Type of Specialized Health Plan

Of the 7,678 total provider disputes submitted during the 2005 reporting period, mental health services plans accounted for 5,413, followed by dental plans with 985 (including plans that are classified as dental/vision), chiropractic plans with 711, and vision plans with 569. The disparity could be due to the fuller range of benefits that mental health plans provide as compared to other

specialized plans. In addition, AB 88 requires full service plans to provide mental health coverage for certain conditions, and often contract with mental health plans to provide coverage for those services, thus increasing the number of enrollees assigned to those specialized plans. Mental health plans received one complaint for every 1,769 enrollees, and full service plans received one complaint for every 51 enrollees.

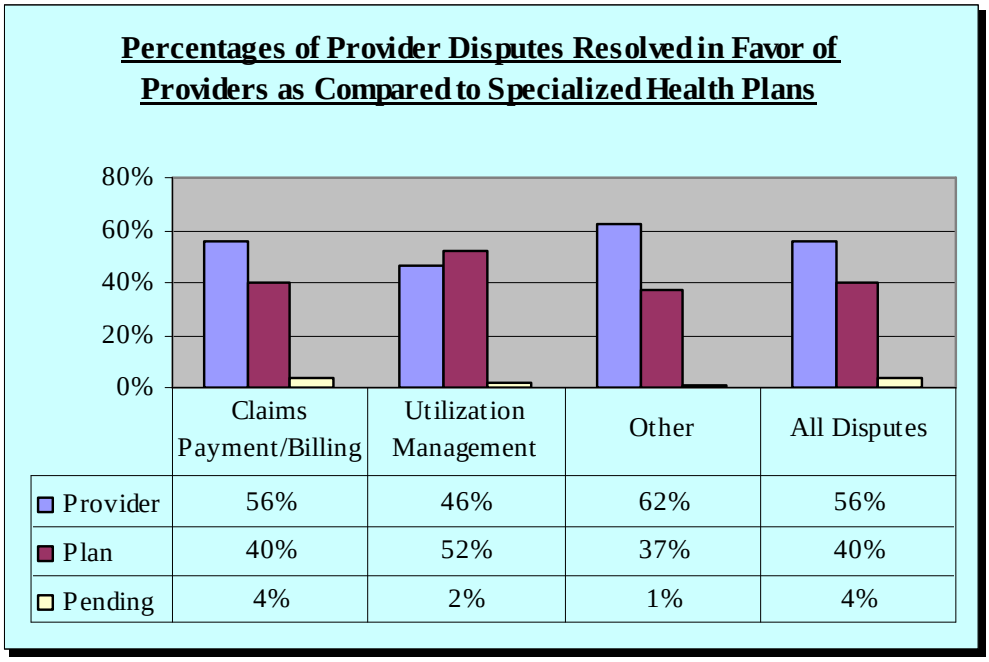
Mental health services plans had the highest percentage increase (more than 90 percent) in the number of reported disputes as compared to the 2004 reporting period. At the present time, the Department does not attribute this increase to greater provider dissatisfaction, but rather the ongoing implementation of the mental health parity mandates and the Department's outreach efforts to educate consumers about the right to receive mental health treatments as part of their medical benefits. The Department is continuing to monitor the level of provider complaints received from mental health providers to chart any emergent trends.

It is also notable that the percentage of vision plan disputes increased by 155 percent and dental plan disputes increased 60 percent from the 2004 reporting.



Summary of the Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 56 percent of provider disputes were resolved in favor of the provider, an increase of one percent from the 2004 reporting period. As seen in the full-service reporting, the high percentage of favorable rulings for providers suggests that dispute resolution mechanisms provide a viable avenue for resolving provider disputes without resorting to costly civil litigation.


Percentages of Provider Disputes Resolved in Favor of Providers as Compared to Specialized Health Plans
80%
60%
40%
20%
0%
Claims Payment/Billing
Utilization Management
Other
All Disputes
Provider 56% 46% 62% 56%
Plan 40% 52% 37% 40%
Pending 4% 2% 1% 4%

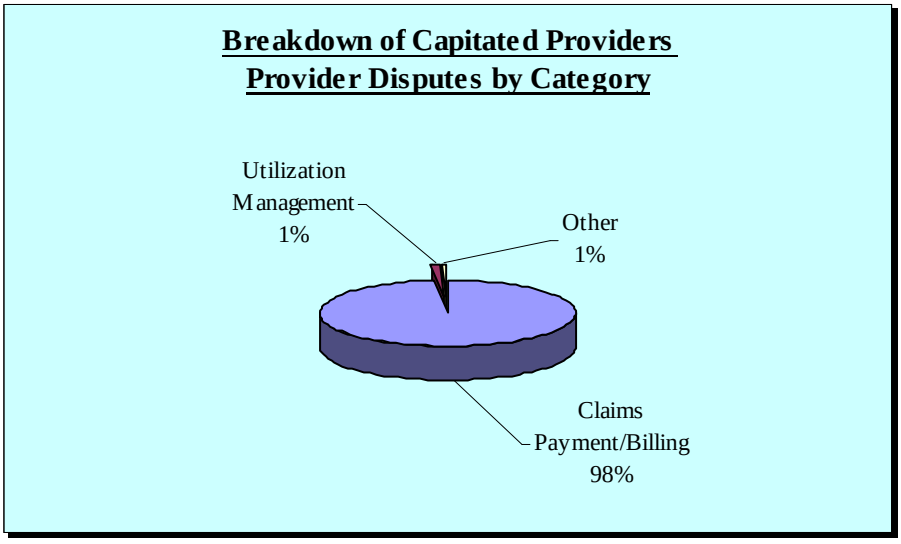
V.

Reporting by Capitated Providers

Beginning on January 1, 2004, all health plans were required to furnish a dispute resolution report for each capitated provider with whom they contract. The Department has identified 418 capitated providers, of which approximately 207 are classified as risk-bearing organizations (RBOs). Capitated providers include all RBOs and any other medical provider that accepts capitation and pays claims for health care services for the plan's enrollees.

A total of 151,390 provider disputes were filed with capitated providers for the reporting period. Capitated providers contracting with specialized health plans reported receiving 98 disputes, or less than one-tenth of one percent (0.06%). More than 99 percent of the provider disputes filed involved capitated providers who contracted with full-service health plans. This result was anticipated, since customarily, it is rare that capitated providers who contract with specialized plans pay claims. The reporting requirements for the capitated providers were similar to full-service and specialized health plan reporting. Nearly all provider disputes (98 percent) received by capitated providers involved claim payment and billing issues. The 2005 reporting period reflects the following breakdown of provider complaints:

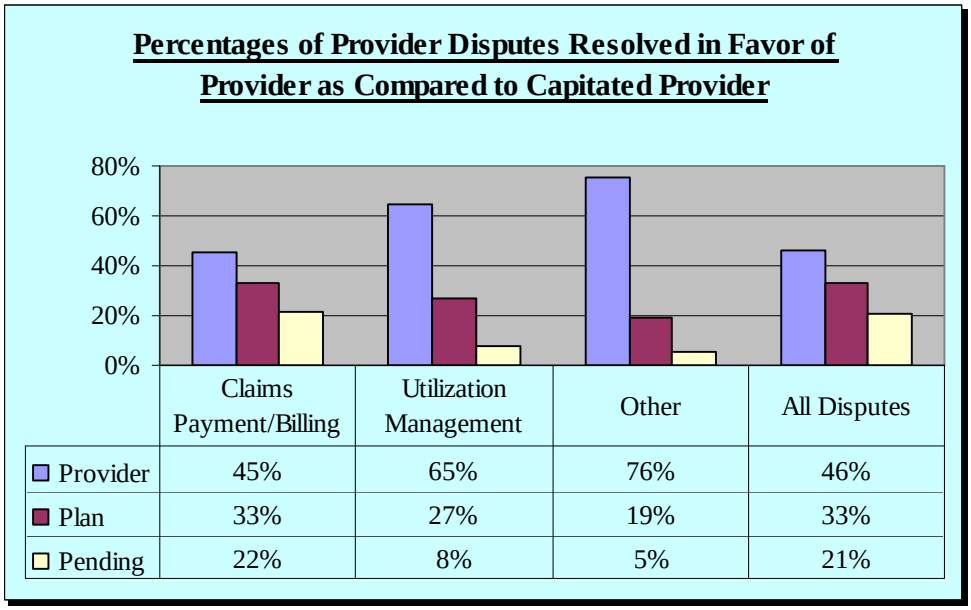
Total number of claims payment/billing disputes	148,799
Total number of utilization management disputes	1,709
Total number of other disputes	882



This was the first reporting period that required capitated providers to report a full year of dispute data. As a result, the Department expects to be in a better position to track and analyze capitated provider data in future reports. The Department, in collaboration with the stakeholders in the industry, will continue to educate capitated providers about accurately tracking and reporting provider dispute data.

Summary of the Disposition of Capitated Providers' Provider Disputes

Based on the information filed on behalf of the capitated providers, 46 percent of all disputes were resolved in favor of the provider. Of the 151,390 provider disputes submitted, 69,090 were determined to be in favor of the provider, 49,626 were in favor of the capitated provider, and 32,674 were pending review as of September 30, 2005. The following graph illustrates the breakdown by percentages for each category of dispute:



	Claims Payment/Billing	Utilization Management	Other	All Disputes
Provider	45%	65%	76%	46%
Plan	33%	27%	19%	33%
Pending	22%	8%	5%	21%

It is difficult to make an assumption regarding information submitted on behalf of the capitated providers, as the information represents only nine months of the reporting year. However, the high percentage of favorable rulings for providers suggests that the health plan dispute resolution mechanisms provide a viable avenue for resolving provider disputes without resorting to costly civil litigation. The Department has instructed health plans to study each of their capitated provider's dispute resolution mechanisms as part of the claims audit process to determine whether the relatively high overturn rate is related to uncorrected systemic claims payment deficiencies, and, if so, to implement appropriate corrective action strategies. The Department will monitor the health plans' compliance with this directive.

VI.

Provider Complaint Unit

In September 2004, the Department rolled out its Provider Complaint Unit (PCU) to provide a mechanism that health care providers could use to submit their claim reimbursement disputes to the Department for resolution. By identifying and tracking trends through the review of individual provider complaints, the Department focuses on patterns of unfair payment and ensures that payors remain compliant with claims timeliness and accuracy requirements.

Before submitting their claim reimbursement disputes to the Department, however, health care providers must first attempt to resolve their disputes through the health care service plans and/or their capitates providers' (payor) dispute resolution processes. If the health care provider disagrees with the payor's decision, or if the dispute has been pending with no decision for 60 calendar days or more, then the provider may submit a claim via the Department's web portal

From October 1, 2004, through September 30, 2005, the PCU received 1,103 complaints, and by the end of the reporting period, had completed a review of all but three, and determined that 869 were under the Department's jurisdiction. As a result of these complaint reviews, health care providers received an additional $332,581 in claim reimbursement. The top five dispute issues received were:

- The payor failed to reimburse a complete claim with the correct payment.
- The payor failed to reimburse the complete claim, or a portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.
- The payor failed to provide a clear and accurate written explanation for the claim adjudication decision.
- The payor failed to include required interest and/or penalty amount(s) owed on claims(s) reimbursed beyond 30 working days for non-HMO services, or 45 working days for HMO services.
- The payor reimbursed a contracting provider's claim at less that the "contract rate."

The complaints received by the Department varied by provider type. The chart below details the number of complaints by provider type:

Provider Type	Number of Complaints	Percentage
Ambulance	35	4%
Anesthesiology	5	1%
Chiropractic	3	0%
Dental	46	5%
Durable Medical Equipment	36	4%
Emergency Room Physicians	3	0%
Family/General Practice	11	1%
Home Health Services	5	1%
Hospital/Institutions	236	27%
Hospital Based Physicians	27	3%
Internal Medicine	24	3%
Laboratory Services	29	4%
Mental Health	42	5%
Obstetrics/Gynecology	56	6%
On-Call Physicians (not Emergency Room)	6	1%
Other Ancillary Services Providers	81	10%
Other Specialty Providers	177	20%
Pediatrics	9	1%
Pharmacy	2	0%
Physical/Occupational/Speech Therapy	22	3%
Skilled Nursing Facility	10	1%
Vision	4	0%
Total	869	100%

VII.

Audits of Health Plans

In February 2005, the Department began auditing payor dispute resolution processes to verify the accuracy and adequacy of the plans' self-reported information. As of September 30, 2005, the Financial Oversight Division completed 19 audits of health care service plans' dispute resolution processes. The results are shown in the chart below:

	Number Not-Met	
Criteria	Full Service	Specialized
95% Dispute Determination Timeliness[4]	5	0
95% Acknowledge Timeliness[5]	7	1
Payment Issued Within Five Working Days[6]	5	1
Interest/Penalty Payment[6]	13	0
Written Determination Issued[7]	4	0
Received Date[8]	4	1
Non-contracted Provider Reimbursement[9]	2	0

Each health plan was required to implement a corrective action plan to remedy each deficiency noted during the audit process. The Department will continue to perform audits of dispute resolution processes.

[4] Rule 1300.71(a)(8)(S) requires health plans to comply with dispute determination timelines enumerated in section 1300.71.38(f) at least 95% of the time over the course of any three-month period.

[5] Rule 1300.71.38(a)(8)(R) requires health plans to acknowledge at least 95% of the provider disputes received consistent with section 1300.71(e) over the course of any three-month period.

[6] Rule 1300.71.38(g) requires health plans to pay monies along with interest and penalties within five (5) working days of the issuance of the Written Determination in disputes decided in favor or the provider.

[7] Rule 1300.71.38(f) requires health plans to issue a written determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

[8] Rule 1300.71.38 (a)(3) defines "Date of receipt" as the working day when the provider dispute is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box, by either physical or electronic means.

[9] Rule 1300.71(a)(3)(B) requires payors to pay non-contracted providers the reasonable and customary value of the services provided.

VIII.

Conclusion

Overall, the 2005 dispute resolution reporting indicates that the total number of reported provider disputes increased modestly over the 2004 reporting. This increase is likely attributable, in part, to more accurate reporting by health plans and capitated providers, and greater awareness by providers of payor's internal dispute resolution mechanism for addressing claims and contract disputes.

The Department acknowledges that the provider dispute resolution data summarized in this report is self-reported, and thus may not include all provider disputes throughout the managed care industry in California, and that there are substantive differences in the way plans identify, quantify and track provider disputes. The quality and accuracy of this data will be further tested through the Department's regular onsite auditing activities, and if deficiencies are noted, the plans will be required to promptly institute appropriate corrective action. The Department's PCU will continue to monitor the industry's compliance efforts in achieving claims payment standards required by AB 1455 and SB 1177.

Information included in this report appears to be representative of the activities health plans and capitated providers have undertaken to implement meaningful provider dispute resolution mechanisms. Overall, the Department is satisfied that the industry has made a good faith effort to implement the regulations for claims settlement practices.

The Department, in collaboration with industry stakeholders, has refined the reporting requirements so that the information reported better reflects the overall claim payment accuracy and the timeliness of the managed care delivery model. The new reporting requirements will be effective October 1, 2005, and will be reflected in the 2006 reporting period.

The Department expects that these regulations will provide greater standardization of dispute resolution mechanisms, and will also provide reasonable timeframes for the resolution of provider disputes. Defining the basic concepts relevant to all dispute resolution mechanisms, as outlined in the regulations for claims settlement practices, will improve consistency in health plan and capitated provider reporting. The Department's ongoing regulatory review of these processes will optimize efficiency and cost reduction, while protecting the public interest and boosting consumer confidence.